



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the St. Cloud
VA Health Care System
Minnesota



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Figure 1. *St. Cloud VA Health Care System, Minnesota (Source: <https://vaww.va.gov/directory/guide/>, accessed on August 27, 2019)*

Abbreviations

ADPCS	associate director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
FPPE	focused professional practice evaluation
FY	fiscal year
LIP	licensed independent practitioner
MST	military sexual trauma
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UCC	urgent care center
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the St. Cloud VA Health Care System (the facility). The inspection covers key clinical and administrative processes that are associated with promoting quality care.

CHIP inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus each year.

The OIG team looks at leadership and organizational risks as well as areas affecting quality patient care. At the time of the inspection, the clinical areas of focus were

1. Quality, safety, and value;
2. Medical staff privileging;
3. Environment of care;
4. Medication management (specifically the controlled substances inspection program);
5. Mental health (focusing on military sexual trauma follow-up and staff training);
6. Geriatric care (spotlighting antidepressant use for elderly veterans);
7. Women's health (particularly abnormal cervical pathology result notification and follow-up); and
8. High-risk processes (specifically the emergency department and urgent care center operations and management).

This unannounced visit was conducted during the week of July 15, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the acting director, chief of staff, associate director for Patient Care Services/nurse executive (ADPCS), and associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure with the Quality, Safety, and Value Executive Leadership Council having oversight for several working groups. The director was the chair of the Quality, Safety, and Value Executive Leadership Council, which ensures that key quality, safety, and value functions are reviewed and monitored on a regular basis.

Most of the facility's leadership team had been working together for nearly two years. The acting director, assigned in May 2019, was the newest member of the team; the associate director, the most tenured member, had been in the position since April 2012. The selected patient experience survey scores for the facility leaders were better than the VHA average and employees appeared generally satisfied with facility leaders.

Additionally, the OIG reviewed accreditation agency findings and sentinel events¹ and did not identify any substantial organizational risk factors.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.² Although the leadership team members were knowledgeable within their areas of responsibility about selected SAIL metrics, the leaders should continue to take actions to sustain and improve performance of the quality of care metrics and measures likely contributing to the facility's community living center (CLC) "2-star" quality rating.³

¹ The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

² VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star rating" system to designate a facility's performance in individual measures, domains, and overall quality.

<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>.

(The website was accessed on March 6, 2019, but is not accessible by the public.)

³ Based on fiscal year 2018, quarter 3 ratings at the time of the site visit.

The OIG noted deficiencies in four of the eight clinical areas reviewed and issued four recommendations that are attributable to the director and chief of staff. These are briefly described below.

Medical Staff Privileging

The facility generally complied with requirements for privileging. However, the OIG had a concern with including required service-specific criteria in ongoing professional practice evaluations.⁴

Mental Health

The OIG team also found the facility complied with many of the performance indicators, including the designation of a Military Sexual Trauma (MST) coordinator, tracking of MST-related data, and provision of clinical care. The OIG noted a concern, however, with providers completing MST training.

Geriatric Care

For geriatric patients, clinicians documented reasons for prescribing medications and reconciliation to minimize duplicative medications and adverse interactions. However, the OIG identified inadequate patient and/or caregiver education related to newly prescribed medications and evaluation of patient/caregiver understanding when education was provided.

Women's Health

The OIG also noted compliance with requirements for a designated women veterans program manager, clinical oversight of the women's health program, tracking data related to cervical cancer screenings, communication of results to patients within the required time frame, and follow-up care when indicated. However, the OIG identified that the Women Veterans Health Committee lacked representation from pharmacy, mental health, radiology, and laboratory.

⁴ The definitions of ongoing professional practice evaluation and focused professional practice evaluations can be found within Office of Safety and Risk Awareness, Office of Quality and Performance, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, July 2016 (Revision 2). An ongoing professional practice evaluation is “the ongoing monitoring of privileged providers to confirm the quality of care delivered and ensures patient safety.” A focused professional practice evaluation is “a time-limited process whereby the clinical leadership evaluates the privilege-specific competence of a provider who does not yet have documented evidence of competently performing the requested privilege(s) at the facility.” A focused professional practice evaluation for cause is “a time-limited period during which the medical staff leadership assesses the provider's professional performance to determine if any action should be taken on the provider's privileges.”

Summary

In reviewing key healthcare processes, the OIG issued four recommendations for improvement directed to the facility director and chief of staff. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network director and facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 59–60, and the responses within the body of the report for the full text of the directors' comments.). The OIG will follow up on the planned actions for the open recommendations until they are completed.



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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to provide oversight of healthcare services to veterans. This focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the St. Cloud VA Health Care System (the facility) is accomplished by examining a broad overview of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions can be made on improving care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.⁵ Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.⁶ Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following nine areas of clinical and administrative operations that support quality care at the facility:

1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff privileging
4. Environment of care
5. Medication management (specifically the controlled substances inspection program)
6. Mental health (focusing on military sexual trauma follow-up and staff training)
7. Geriatric care (spotlighting antidepressant use for elderly veterans)
8. Women's health (particularly abnormal cervical pathology results notification and follow-up)

⁵ Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/>. (The website was accessed on January 24, 2019.)

⁶ Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. <http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen>. (The website was accessed on January 24, 2019.)

9. High-risk processes (specifically the emergency department and urgent care center operations and management).⁷

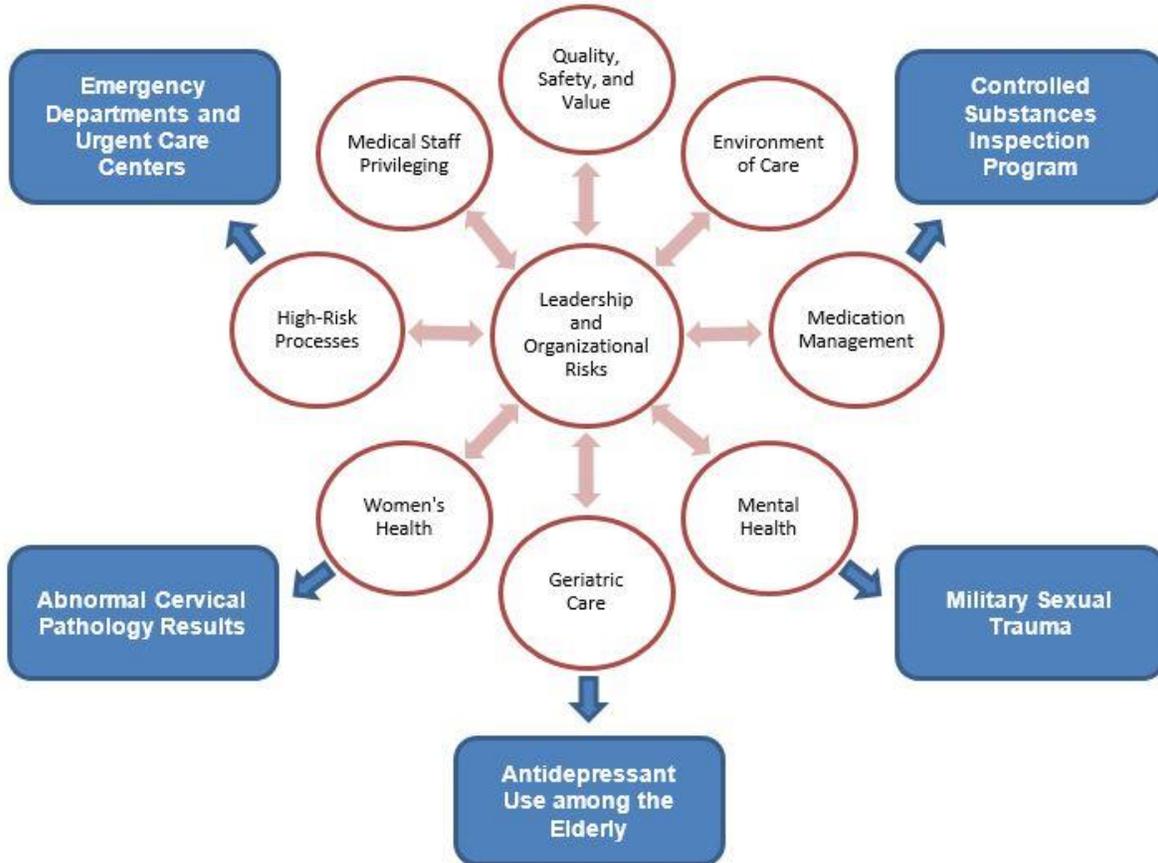


Figure 2. Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services
Source: VA OIG

⁷ See Figure 2. CHIP inspections address these processes during FY 2019 (October 1, 2018, through September 30, 2019); they may differ from prior years' focus areas.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;⁸ physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from November 8, 2014, through July 19, 2019, the last day of the unannounced week-long site visit.⁹ While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the facility completes corrective actions. The facility director's comments submitted in response to the report recommendations appear within each topic area.

The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reports and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

⁸ The OIG did not review VHA's internal survey results, instead focusing on OIG inspections and external surveys that affect facility accreditation status.

⁹ The range represents the time period from the last Combined Assessment Program review, which was performed prior to the comprehensive healthcare inspection, to the completion of the unannounced week-long CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.¹⁰ To assess the facility's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation and/or for-cause surveys and oversight inspections
5. Factors related to possible lapses in care
6. VHA performance data

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of an acting Health Care System director (director), chief of staff, associate director for Patient Care Services/nurse executive (ADPCS), and Health Care System associate director (associate director) (primarily nonclinical). The chief of staff and ADPCS oversee patient care, which requires managing service directors and chiefs of programs and practices.

¹⁰ L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on February 2, 2017.)

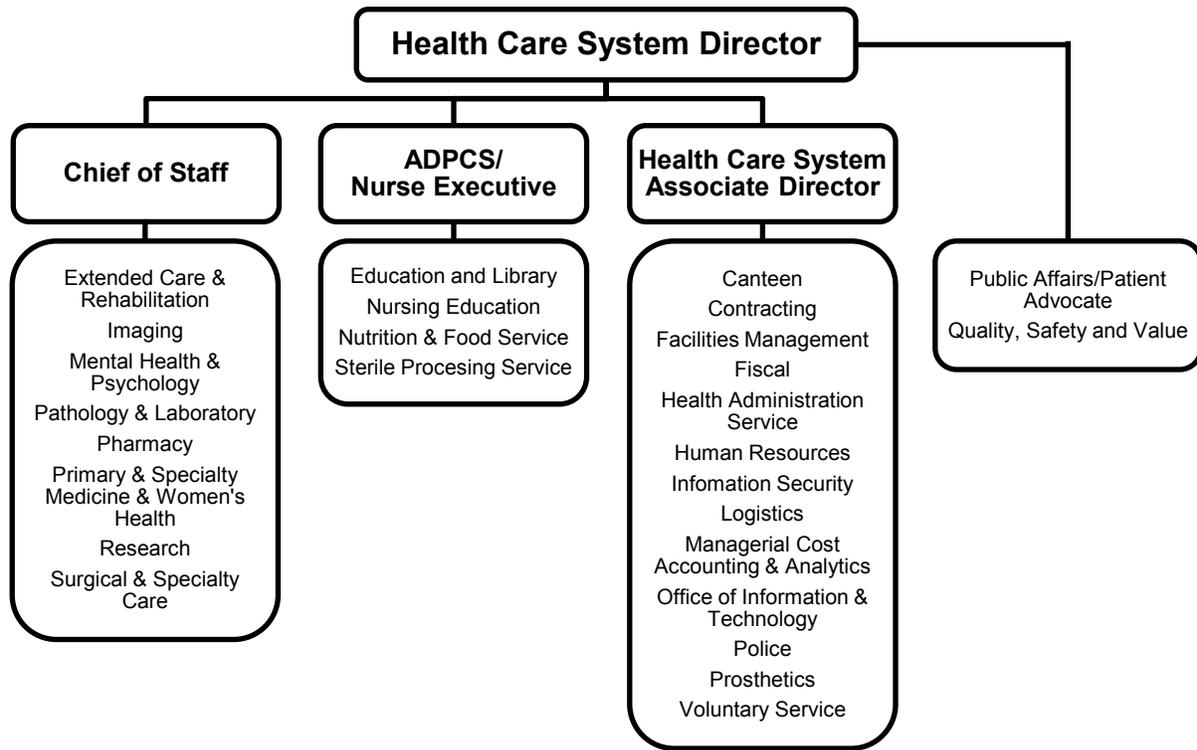


Figure 3. Facility Organizational Chart¹¹
 Source: St. Cloud VA Health Care System (received July 17, 2019)

At the time of the OIG site visit, the acting facility director had been working with the executive team for two months, while the three remaining executive team members had worked together since October 2017. See Table 1.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	May 3, 2019 (acting)
Chief of staff	October 1, 2017
Associate director for Patient Care Services/nurse executive	April 5, 2015
Associate director	April 8, 2012

Source: St. Cloud VA Health Care System chief human resources officer (received July 16, 2019)

¹¹ At this facility, the health care system director is responsible for Public Affairs/Patient Advocate and Quality, Safety and Value.

To help assess facility executive leaders' engagement, the OIG interviewed the acting director, chief of staff, ADPCS, and associate director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders were generally knowledgeable within their scope of responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics and SAIL community living center (CLC) measures. These are discussed in greater detail below.

The director serves as the chairperson of the Executive Leadership Board, which is responsible for advising and assisting the director in shared leadership and governance of the organization; establishing the strategic vision; and ensuring high-quality patient care, effective financial management, and overall organizational performance of the health care system. The Executive Leadership Board oversees various working groups, such as the Quality, Safety, and Value Executive Council; the Resource Executive Council; and the Medical Staff Executive Council.

These leaders are also engaged in monitoring patient safety and care through the Quality, Safety, and Value Executive Council, for which the director is the designated chair, and the director of Quality, Safety, and Value is the designated co-chair. The Quality, Safety, and Value Executive Council is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes, and it reports to the Executive Leadership Board. See Figure 4. The Quality, Safety, and Value Executive Council minutes indicated the previous director and current acting director did not chair the committee. Additionally, the current acting director did not attend the one Quality, Safety, and Value Executive Council meeting held since being detailed to the position. The acting facility director reported that this was due to an administrative oversight.

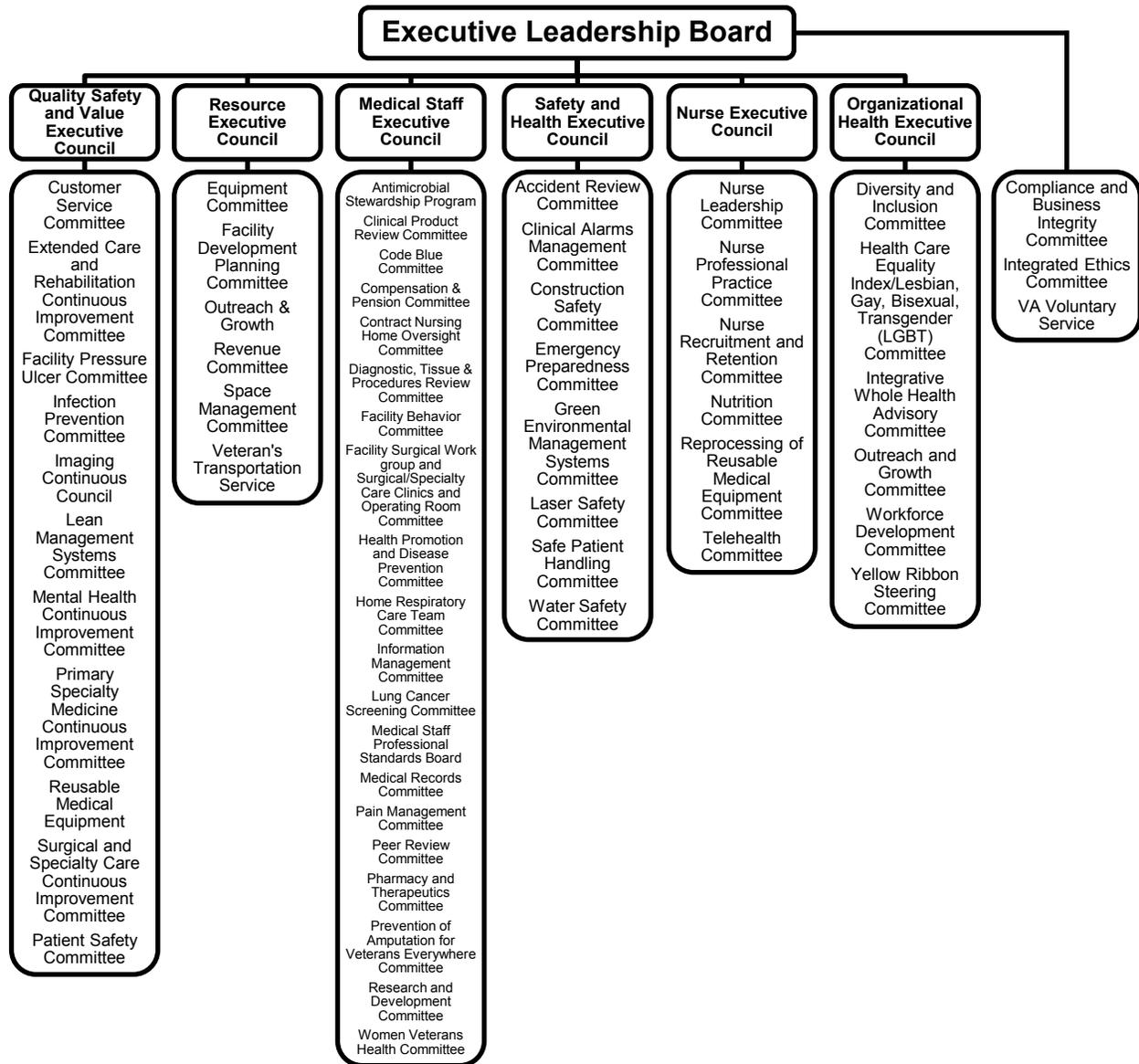


Figure 4. Facility Committee Reporting Structure¹²

Source: St. Cloud VA Health Care System (received July 17, 2019; updated structure received November 15, 2019)

¹² The Executive Leadership Board directly oversees the Compliance and Business Integrity Committee, Integrated Ethics Committee, and VA Voluntary Service.

Employee Satisfaction

The All Employee Survey is an “annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential.” Since 2001, the instrument has been refined several times in response to VA leaders’ inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on facility leadership.

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results from VHA’s All Employee Survey that relate to the period of October 1, 2017, through September 30, 2018.¹³ Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA’s All Employee Survey. The OIG found the facility average was generally similar to the VHA average.¹⁴ Members of the executive leadership team scored higher than the VHA and facility average. In all, employees appear generally satisfied with facility leaders.¹⁵

**Table 2. Survey Results on Employee Attitudes toward Facility Leadership
(October 1, 2017, through September 30, 2018)**

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>Servant Leader Index Composite</i> ¹⁶	0–100 where HIGHER scores are more favorable	71.7	68.2	88.3	93.6	91.7	92.1

¹³ Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPCS, and associate director.

¹⁴ The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

¹⁵ It is important to note that the 2018 All Employee Survey results are not reflective of employee satisfaction with the current acting director.

¹⁶ According to the 2018 VA All Employee Survey Questions by Organizational Health Framework, Servant Leader Index “is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others’ contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others’ needs before their own.”

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.4	4.6	4.3	4.6	4.3
All Employee Survey: <i>My organization's senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.5	4.6	4.3	4.4	4.5
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.6	4.7	4.4	4.9	4.6

Source: VA All Employee Survey (accessed June 4, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA’s All Employee Survey. Note that the executive leadership team averages for the selected survey questions were higher than the VHA and facility averages except for the ADPCS and associate director for moral distress. Facility leaders appear to be maintaining an environment where employees generally feel safe bringing forth issues and concerns.

Table 3. Survey Results on Employee Attitudes toward the Workplace (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.8	4.6	4.6	4.3	4.6

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.5	4.9	4.8	4.2	4.4
All Employee Survey: <i>In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?</i>	0 (Never) – 6 (Every Day)	1.5	1.5	0.7	1.0	2.0	2.0

Source: VA All Employee Survey (accessed June 4, 2019)

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through September 30, 2018. VHA’s Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients’ experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.¹⁷

VHA also collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to two of the four survey questions applicable to

¹⁷ Ratings are based on responses by patients who received care at this facility.

this facility that reflect patients’ attitudes toward facility leaders (see Table 4).¹⁸ For this facility, both patient survey results reflected better care ratings than the VHA average. Patients were generally satisfied with the leadership and care provided.

Table 4. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	66.9	n/a
Survey of Healthcare Experiences of Patients (inpatient): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	84.2	n/a
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	76.3	89.6
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	76.5	81.9

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28, 2018)

¹⁸ The facility does not have inpatient beds; therefore, the two inpatient survey questions are not applicable (n/a).

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.¹⁹ Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).²⁰ Indicative of effective leadership, the facility has closed all recommendations for improvement.²¹

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.²² Additionally, the OIG noted that the most recent Long Term Care Institute inspection of the facility's CLC in October 2018 had five open recommendations.²³ The facility developed a corrective action plan after receipt of the Long Term Care Institute inspection report and was actively working to remedy the deficiencies.

¹⁹ The Joint Commission (TJC) conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.

²⁰ According to VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017, TJC provides an "internationally accepted external validation that an organization has systems and processes in place to provide safe and quality-oriented health care." TJC "has been accrediting VA medical facilities for over 35 years." Compliance with TJC standards "facilitates risk reduction and performance improvement."

²¹ A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

²² According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs*, May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs. According to the College of American Pathologists, for 70 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." College of American Pathologists. <https://www.cap.org/about-the-cap>. (The website was accessed on February 20, 2019.) In accordance with VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

²³ The Long Term Care Institute states that it has been to over 4,000 healthcare facilities conducting quality reviews and over 1,145 external regulatory surveys since 1999. The Long Term Care Institute is "focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings." Long Term Care Institute. <http://www.ltciorg.org/about-us/>. (The website was accessed on March 6, 2019.)

Table 5. Office of Inspector General Inspections/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (<i>Combined Assessment Program Review of the St. Cloud VA Health Care System, St. Cloud, Minnesota, Report No. 14-04218-92, January 26, 2015</i>)	November 2014	1	0
OIG (<i>Review of Community Based Outpatient Clinics and Other Outpatient Clinics of St. Cloud VA Health Care System, St. Cloud, Minnesota, Report No. 14-04382-86, January 21, 2014</i>)	November 2014	1	0
OIG (<i>Healthcare Inspection, Quality of Care Concerns at Two Veterans Integrated Service Network 23 Facilities and a Veterans Readjustment Counseling Center, Report No. 15-00509-301, July 17, 2017</i>)	October 2014	2	0
TJC Hospital Accreditation	October 2016	11	0
TJC Behavioral Health Care Accreditation		3	0
TJC Home Care Accreditation		0	0

Source: OIG and TJC (inspection/survey results verified with the chief of staff on July 16, 2019)

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from November 8, 2014 (the prior comprehensive OIG inspection), through July 19, 2019.²⁴

²⁴ It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the St. Cloud VA Health Care System is a low complexity (3) affiliated facility as described in Appendix B.)

**Table 6. Summary of Selected Organizational Risk Factors
(November 8, 2014, through July 19, 2019)**

Factor	Number of Occurrences
Sentinel Events ²⁵	1
Institutional Disclosures ²⁶	18
Large-Scale Disclosures ²⁷	0

Source: St. Cloud VA Health Care System’s risk manager (received July 16, 2019)

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes “measures on healthcare quality, employee satisfaction, access to care, and efficiency.” It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to “understand the similarities and differences between the top and bottom performers” within VHA.²⁸

VA also uses a star-rating system where facilities with a “5-star” rating are performing within the top 10 percent of facilities and “1-star” facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.²⁹ As of June 30, 2018, the facility was rated as “5-star” for overall quality.

²⁵ The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient “death, permanent harm, or severe temporary harm and intervention required to sustain life.”

²⁶ According to VHA Directive 1004.08, *Disclosure of Adverse Events To Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an “administrative disclosure”) as “a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or [his or her] personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.”

²⁷ VHA Directive 1004.08 defines large-scale disclosures of adverse events (sometimes referred to as “notifications”) as “a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.”

²⁸ VHA Support Service Center (VSSC), *The Strategic Analytics for Improvement and Learning (SAIL) Value Model*, <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public.)

²⁹ According to the methods established by the SAIL Model, this is based on normal distribution ranking of the quality domain for 130 VA Medical Centers.

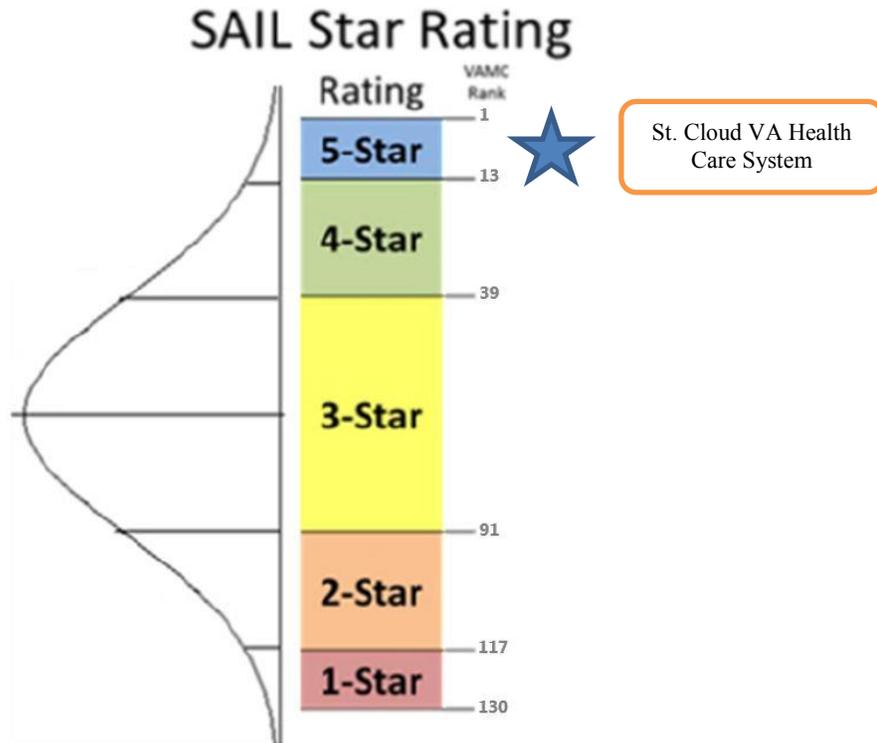


Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)
 Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed June 4, 2019)

Figure 6 illustrates the facility’s quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of patient-centered medical home (PCMH) care coordination, mental health (MH) continuity (of) care, and rating (of) primary care (PC) provider). Metrics that need improvement are denoted in orange, specifically call responsiveness and efficiency.³⁰

³⁰ For information on the acronyms in the SAIL metrics, please see Appendix D.

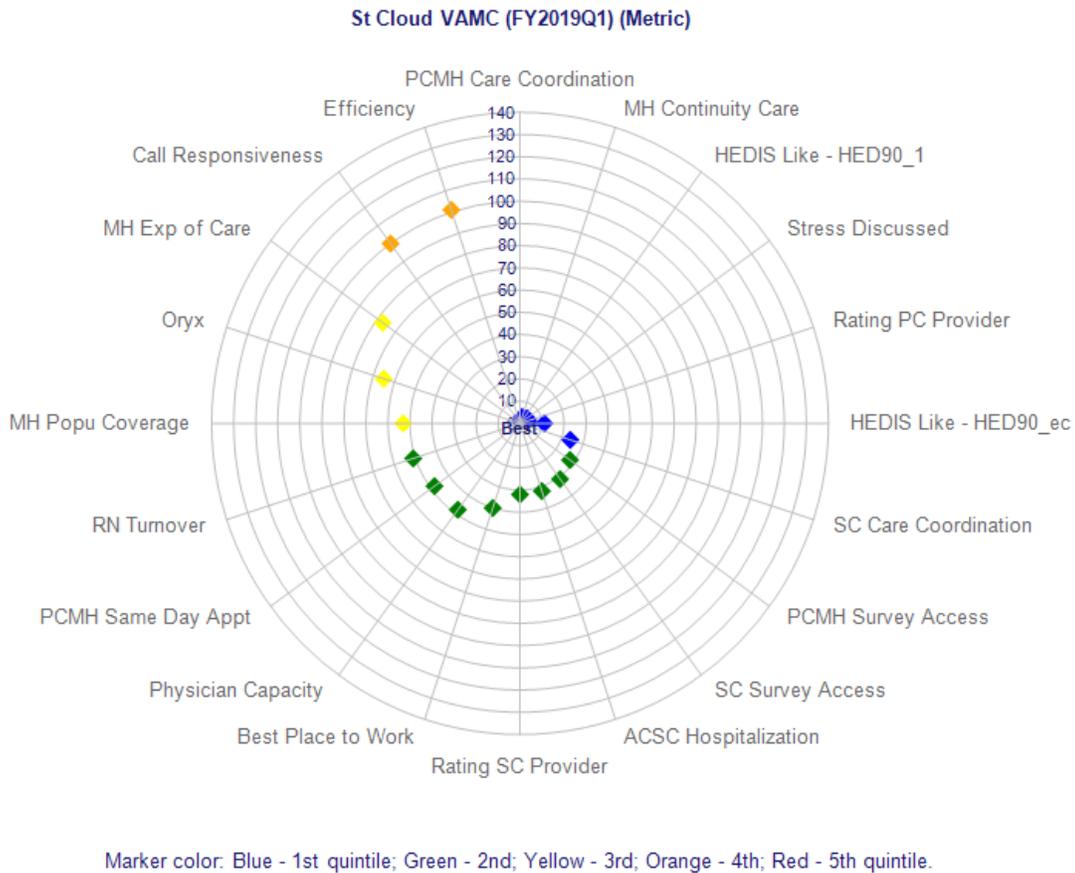


Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2018)

Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

The SAIL Value Model also includes “SAIL CLC,” which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in The Centers for Medicare & Medicaid Services’ (CMS) *Nursing Home Compare*.³¹ The SAIL CLC provides a single resource to review quality measures and health inspection results. It

³¹ According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, August 22, 2019, “In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several “star” ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes.”

includes star ratings for an unannounced survey, staffing, quality, and overall results.³² Table 7 summarizes the rating results for the facility’s CLC as of June 30, 2018. The facility has an overall “2-star” rating, and its rating for quality is also a “2-star.”

**Table 7. Facility CLC Star Ratings
(as of June 30, 2018)**

Domain	Star Rating
Unannounced Survey	1
Staffing	5
Quality	2
Overall	2

Source: VHA Support Service Center

In exploring the reasons for the “2-star” quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 7 illustrates the facility’s CLC quality rankings and performance compared with other VA CLCs as of March 30, 2019. The figure uses blue data points to indicate high performance in the areas of physical restraints–long stay (LS) and high risk pressure ulcer (PU) (LS). Metrics that need improvement and were likely the reasons why the facility had a “2-star” for quality are denoted in orange and red (for example, improvement in function–short stay (SS), newly received antipsychotic (Antipsych) medications (Meds) (SS), and receive antipsychotic (Antipsych) medications (Meds) (LS)).³³

³² *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>. (The website was accessed on September 3, 2019, but is not accessible by the public.)

³³ For data definitions of acronyms in the SAIL CLC measures, please see Appendix E.

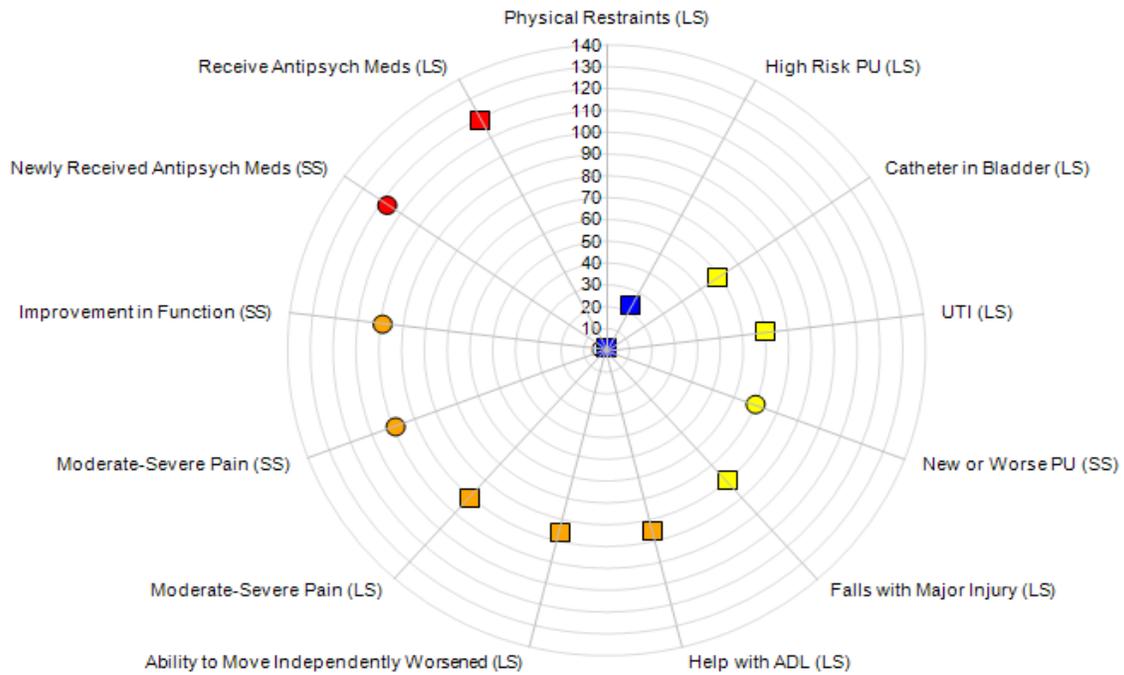


Figure 7. Facility CLC Quality Measure Rankings (as of March 30, 2019)

LS = Long-Stay Measure SS = Short-Stay Measure

Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility’s executive leadership team appeared relatively stable. The selected employee satisfaction and patient experience survey scores for the facility leaders were generally better than the VHA and facility averages, and facility leaders appeared to be actively engaged with patients. Facility executive leaders appeared to support efforts to improve and sustain employee satisfaction and to provide an environment where employees feel encouraged to do the right thing. The OIG’s review of the facility’s accreditation findings and sentinel events did not identify any substantial organizational risk factors. The leadership team was knowledgeable within their scope of responsibility about selected SAIL and SAIL CLC metrics but should continue to take actions to sustain and improve performance of measures contributing to the SAIL “5-star” and CLC “2-star” quality ratings.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.³⁴ VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.³⁵ VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.³⁶

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's enterprise framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,³⁷ utilization management (UM) reviews,³⁸ patient safety incident reporting with related root cause analyses,³⁹ and cardiopulmonary resuscitation (CPR) episode reviews.⁴⁰

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.⁴¹

³⁴ VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 but was rescinded on October 24, 2019.)

³⁵ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

³⁶ VHA Directive 1026.

³⁷ The definition of a peer review can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a critical review of care, performed by a peer, to evaluate care provided by a clinician for a specific episode of care, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements.

³⁸ According to VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria." This directive expired July 31, 2019.

³⁹ The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

⁴⁰ VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

⁴¹ VHA Directive 1190.

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.⁴²

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.⁴³

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR Committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.⁴⁴

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:⁴⁵

- Protected peer reviews
 - Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
 - Implementation of improvement actions recommended by the Peer Review Committee
 - Completion of final reviews within 120 calendar days
 - Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee

⁴² VHA Directive 1117(2).

⁴³ VHA Handbook 1050.01.

⁴⁴ VHA Directive 1177, VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017.

⁴⁵ For CHIP inspections, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit⁴⁶
- UM
 - Completion of at least 75 percent of all required inpatient reviews
 - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
 - Interdisciplinary review of UM data
- Patient safety
 - Annual completion of a minimum of eight root cause analyses⁴⁷
 - Inclusion of required content in root cause analyses (generally)
 - Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
 - Provision of feedback about root cause analysis actions to reporting employees
 - Submission of annual patient safety report to facility leaders
- Resuscitation episode review
 - Evidence of a committee responsible for reviewing resuscitation episodes
 - Confirmation of actions taken during resuscitative events being consistent with patients' wishes
 - Evidence of basic or advanced cardiac life support certification for code team responders
 - Evaluation of each resuscitation episode by the CPR Committee or equivalent

Quality, Safety, Value Conclusion

Generally, the facility achieved the performance indicators listed above. The OIG made no recommendations.

⁴⁶ VHA Directive 1190.

⁴⁷ According to VHA Handbook 1050.01, "the requirement for a total of eight [root cause analyses] and Aggregated Reviews is a minimum number, as the total number of [root cause analyses] is driven by the events that occur and the [Safety Assessment Code] SAC score assigned to them. At least four analysis per fiscal year must be individual [root cause analyses], with the balance being Aggregated Reviews or additional individual [root cause analyses]."

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of “all healthcare professionals who are permitted by law and the facility to practice independently”—“without supervision or direction, within the scope of the individual’s license, and in accordance with individually granted clinical privileges.” These healthcare professionals are also referred to as licensed independent practitioners (LIPs).⁴⁸

Clinical privileges need to be specific, based on the individual’s clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to their expiration.⁴⁹

VHA defines the focused professional practice evaluation (FPPE) as “a time-limited period during which the medical staff leadership evaluates and determines the practitioner’s professional performance. The FPPE typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges.” “The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered.”⁵⁰

According to TJC, the “FPPE for Cause” should be used when a question arises regarding a privileged provider’s ability to deliver safe, high-quality patient care. The “FPPE for Cause” is limited to a particular time frame and customized to the specific provider and related clinical concerns.⁵¹ Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.⁵²

To determine whether the facility complied with requirements for privileging, the OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members:

⁴⁸ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This VHA handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

⁴⁹ VHA Handbook 1100.19.

⁵⁰ VHA Handbook 1100.19.

⁵¹ Office of Safety and Risk Awareness, Office of Quality and Performance, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, July 2016 (Revision 2).

⁵² VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009. (This VHA handbook was scheduled for recertification on or before the last working date of December 2014 and has not been recertified.)

- Six solo or few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months⁵³
- Five LIPs hired within 18 months before the site visit
- Twenty LIPs re-privileged within 12 months before the visit
- No providers underwent a FPPE for cause within 12 months prior to the visit

The OIG evaluated the following performance indicators:

- Privileging
 - Privileges requested by the provider
 - Facility-specific
 - Service-specific
 - Provider-specific⁵⁴
 - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
 - Criteria defined in advance
 - Use of required criteria in FPPEs for selected specialty LIPs
 - Results and time frames clearly documented
 - Evaluation by another provider with similar training and privileges
 - Executive Committee of the Medical Staff's consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
 - Criteria specific to the service or section
 - Use of required criteria in OPPEs for selected specialty LIPs

⁵³ The 18-month period was from January 15, 2018, through July 15, 2019. The 12-month review period covered July 15, 2018, through July 15, 2019; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers "few practitioners" as being fewer than three providers in the facility that are privileged in a particular specialty.

⁵⁴ According to VHA Handbook 1100.19, facility-specific means that privileges are granted only for procedures and types of services performed at the facility; service-specific refers to privileges being granted in a specific clinical service, such as neurology; and provider-specific means that the privileges should be granted to the individual provider based on their clinical competence and capabilities.

- Service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities
- Evaluation by another provider with similar training and privileges
- Executive Committee of the Medical Staff's decision to recommend continuing privileges based on OPPE results
- Focused professional practice evaluations for cause
 - Clearly defined expectations/outcomes
 - Time-limited
 - Provider's ability to practice independently not limited for more than 30 days
 - Shared with the provider in advance
- Reporting of privileging actions to National Practitioner Data Bank

Medical Staff Privileging Conclusion

The facility generally complied with requirements for privileging. However, the OIG had a concern with the required service-specific criteria in ongoing professional practice evaluations that warranted a recommendation for improvement.

For OPPEs, VHA requires each service chief to establish service-specific criteria for granting clinical privileges. These privileges should be consistent with the needs of the service and facility and reflective of available resources.⁵⁵ The OIG noted that 4 of 26 OPPE profiles reviewed (including one solo provider) did not include the required service-specific criteria. This resulted in LIPs providing care without a thorough evaluation of their competency, which could potentially impact the quality of care and patient safety. The urgent care service line manager reported that service-specific criteria was not developed due to insufficient knowledge of the requirement.

Recommendation 1

1. The chief of staff makes certain that service chiefs include service-specific criteria in ongoing professional practice evaluations and monitors service chiefs' compliance.

⁵⁵ VHA Handbook 1100.19.

Facility concurred.

Target date for completion: July 31, 2020

Facility response: The Chief of Staff is responsible for compliance of this recommendation. On November 4, FY2020 Primary & Specialty Medicine Women's Health Service Line Ongoing Professional Practice (OPPE) Forms were revised to include the specific procedures for each specialty. These forms will be presented to Medical Staff Professional Standards Board on November 6, 2019. If approved, these will be implemented for Quarter 1 FY2020 data.

100% of all Ongoing Professional Performance Evaluation forms submitted to the Medical Staff Professional Standards Board between February 2020 through July 2020 will be reviewed monthly to verify inclusion for specialty-specific criteria.

Numerator = Number of Ongoing Professional Performance Evaluations with specialty specific criteria provided to Medical Staff Professional Standards Board.

Denominator = All Ongoing Professional Performance Evaluations forms from February 2020 through July 2020 submitted monthly to the Medical Staff Professional Standards Board.

A compliance rate of 90% will be achieved for six consecutive months. The data will be presented at the Medical Staff Professional Standards Board monthly meeting on an ongoing basis to monitor for compliance and sustainment.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.⁵⁶

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.⁵⁷

VHA requires its facilities to have the “capacity for [providing] mental health services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting;” however, for facilities that do not have inpatient mental health services, that “capacity” could mean facilitating care at a nearby VA or non-VA facility.⁵⁸

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities’ efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.⁵⁹ Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,⁶⁰

⁵⁶ VHA Directive 1608, *Comprehensive Environment of Care (CEOC Program)*, February 1, 2016.

⁵⁷ Applicable requirements for high-risk areas and emergency management include those detailed in or by various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

⁵⁸ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (This VHA handbook was scheduled for recertification on or before the last working date of September 2018 and has not been recertified.)

⁵⁹ VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

⁶⁰ VHA Directive 1028, *Electrical Power Distribution Systems*, July 25, 2014. (This VHA directive was scheduled for recertification on or before the last working date of July 2019 and has not been recertified.)

Occupational Safety and Health Administration,⁶¹ and National Fire Protection Association standards.⁶² The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.⁶³

In all, the OIG team inspected 15 areas—the inpatient mental health unit; post-anesthesia care unit; ambulatory surgery center; women’s clinic; primary care team 1; medical subspecialty clinic team 2; medical subspecialty clinic team 3; outpatient primary care team 4/5; CLCs 49-1, 49-2, 50-1, 50-2, 51-1, and 51-2; and urgent care center. The team also inspected the Max J. Beilke Department of Veterans Affairs Outpatient Clinic. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
 - General safety
 - Environmental cleanliness and infection prevention
 - General privacy
 - Women veterans program
 - Availability of medical equipment and supplies
- Community based outpatient clinic
 - General safety
 - Environmental cleanliness and infection prevention
 - General privacy
 - Women veterans program
 - Availability of medical equipment and supplies
- Locked inpatient mental health unit
 - Mental health environment of care rounds
 - Nursing station security

⁶¹ The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA’s mission is to assure safe and healthy working conditions “by setting and enforcing standards and by providing training, outreach, education, and assistance.” <https://www.osha.gov/about.html>. (This website was accessed on June 28, 2018.)

⁶² The National Fire Protection Association (NFPA) is a global nonprofit organization “devoted to eliminating death, injury, property, and economic loss due to fire, electrical, and related hazards.” <https://www.nfpa.org/About-NFPA>. (This website was accessed on June 28, 2018.)

⁶³ TJC. Environment of Care standard EC.02.05.07.

- Public area and general unit safety
- Patient room safety
- Infection prevention
- Availability of medical equipment and supplies
- Emergency management
 - Hazard vulnerability analysis (HVA)
 - Emergency operations plan (EOP)
 - Emergency power testing and availability

Environment of Care Conclusion

Generally, the facility met requirements as reflected by the performance indicators above. The OIG did not note any issues with availability of medical equipment and supplies. The OIG made no recommendations.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.⁶⁴ Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.⁶⁵

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.⁶⁶

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for the prior two completed quarters;⁶⁷ and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
 - Monthly summary of findings to the director
 - Quarterly trend reports to the director
 - Quality Management Committee’s review of monthly and quarterly trend reports
 - Actions taken to resolve identified problems
- Pharmacy operations
 - Staff restrictions for monthly review of balance adjustments⁶⁸
- Requirements for controlled substances inspectors

⁶⁴ Drug Enforcement Agency Controlled Substance Schedules. <https://www.deadiversion.usdoj.gov/schedules/>. (The website was accessed on March 7, 2019.)

⁶⁵ American Society of Health-System Pharmacists, “ASHP Guidelines on Preventing Diversion of Controlled Substances,” *American Journal of Health-System Pharmacists*, 74, no. 5 (March 1, 2017): 325-348.

⁶⁶ VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

⁶⁷ The two quarters were from January 1, 2019, through June 30, 2019.

⁶⁸ Controlled substances balance adjustment reports list transactions in which the pharmacy vault inventory balance was manually adjusted.

- No conflicts of interest
- Appointed in writing by the director for a term not to exceed three years
- Hiatus of one year between any reappointment
- Completion of required annual competency assessment
- Controlled substances area inspections
 - Completion of monthly inspections
 - Rotations of controlled substances inspectors
 - Patterns of inspections
 - Completion of inspections on day initiated
 - Reconciliation of dispensing between pharmacy and each dispensing area
 - Verification of controlled substances orders
 - Performance of routine controlled substances inspections
- Pharmacy inspections
 - Monthly physical counts of the controlled substances in the pharmacy
 - Completion of inspections on day initiated
 - Security and verification of drugs held for destruction⁶⁹
 - Accountability for all prescription pads in pharmacy
 - Verification of hard copy controlled substances prescriptions
 - Verification of twice a week (three days apart) inventories of the main vault⁷⁰
 - Quarterly inspections of emergency drugs
 - Monthly checks of locks and verification of lock numbers
- Facility review of override reports⁷¹

⁶⁹ According to VHA Directive 1108.02(1), the Destructions File Holding Report “lists all drugs awaiting local destruction or turn-over to a reverse distributor.” Controlled substances inspectors “must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.”

⁷⁰ VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (This handbook was rescinded on May 1, 2019, and replaced by VHA Directive 1108.01, *Controlled Substances Management*.)

⁷¹ When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists’ review of medications ordered by the providers.

Medication Management Conclusion

Generally, the facility achieved the performance indicators listed above. The OIG made no recommendations.

Mental Health: Military Sexual Trauma Follow-Up and Staff Training

The Department of Veterans Affairs uses the term “military sexual trauma” (MST) to refer to a “psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training.”⁷² MST is an experience, not a diagnosis or a mental health condition. Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.⁷³

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.⁷⁴ Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.⁷⁵

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system.⁷⁶ Those who screen positive must have access to appropriate MST-related care.⁷⁷ VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.⁷⁸

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.⁷⁹ All mental health and primary care providers must complete MST mandatory

⁷² VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018.

⁷³ Military Sexual Trauma. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. (The website was accessed on November 17, 2017.)

⁷⁴ VHA Directive 1115.

⁷⁵ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008 (amended November 16, 2015). (This VHA handbook was scheduled for recertification on or before the last working date of September 2013 and has not been recertified.)

⁷⁶ VHA Directive 1115 states that “MST-related care is not subject to the minimum active duty service requirement set forth in 38 U.S.C. 5303A; Veterans may therefore be able to receive MST-related care even if they are not eligible for VA health care under other treatment authorities.”

⁷⁷ VHA Directive 1115.

⁷⁸ VHA Handbook 1160.01.

⁷⁹ VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.⁸⁰

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 37 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Designated facility MST coordinator
 - Establishes and monitors MST-related staff training
 - Establishes and monitors informational outreach
 - Communicates MST-related issues, services, and initiatives with local leaders
- Evidence of tracking MST-related data
- Provision of clinical care
 - Referral for MST-related care to patients with positive MST screens
 - Initial evaluation within 24 hours of referral for mental health services
 - Comprehensive diagnostic and treatment planning evaluation within 30 days of referral for mental health services
- Completion of MST mandatory training requirement for mental health and primary care providers

Mental Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including the designation of an MST coordinator, tracking of MST-related data, and provision of clinical care. Concern about providers completing MST mandatory training warranted a recommendation for improvement.

VHA requires that all mental health and primary care providers complete the MST mandatory training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.⁸¹ The OIG found that 4 of 12 providers hired after July 1, 2012, did

⁸⁰ VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017; Acting Deputy Under Secretary for Health for Operations and Management, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

⁸¹ Acting Deputy Under Secretary for Health for Operations and Management.

not complete the required training within 90 days after entering their positions. This could potentially prevent clinicians from providing a consistent level of counseling, care, and service to veterans who experienced MST. The MST coordinator and the talent management system (TMS) manager reported a TMS assignment issue and insufficient tracking as reasons for noncompliance.⁸²

Recommendation 2

2. The chief of staff confirms that mental health and primary care providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: Starting November 4, 2019, Human Resources will send a bi-monthly report of new employees with job codes required to receive Military Sexual Trauma (MST) Training. On a bi-monthly basis, a Talent Management System (TMS) report on the completion status of the MST Trainings will be sent by Education & Library staff to the MST Coordinator. The MST Coordinator will review the report and notify supervisors of employees who have not completed the training to ensure compliance within 90 days of hire.

Numerator = Number of new employees who have completed the MST Training per requirement.

Denominator = All new employees required to complete MST Training per assigned job code.

A compliance rate of 90% will be achieved for six consecutive months. The data will be presented at the Quality, Safety, and Value Executive Council (co-chaired by the facility Director) monthly meeting on an ongoing basis to monitor for compliance and sustainment.

⁸² TMS Talent Management System is the system of record for all Veterans Affairs (VA) training.

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."⁸³ The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.⁸⁴

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepressant drugs, psychotherapy, or a combination of both."⁸⁵

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.⁸⁶ The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."⁸⁷ In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.⁸⁸ Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.⁸⁹ The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

⁸³ Hans Peterson, "Late Life Depression," *U.S. Department of Veterans Affairs, Mental Health Featured Article*, March 1, 2011. https://www.mentalhealth.va.gov/featureArticle_Mar11LateLife.asp. (The website was accessed on March 8, 2019.)

⁸⁴ *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. <https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf>. (The website was accessed November 20, 2018.)

⁸⁵ Centers for Disease Control and Prevention, "Depression is Not a Normal Part of Growing Older," January 31, 2017. <https://www.cdc.gov/aging/mentalhealth/depression.htm>. (The website was accessed on March 8, 2019.)

⁸⁶ American Geriatrics Society 2015 Beers Criteria Update Expert Panel, "American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." http://www.sgot.org/allegato_docs/1057_Beers-Criteria.pdf. (The website was accessed on March 22, 2018.)

⁸⁷ TJC. Provision of Care, Treatment, and Services standard PC.02.03.01.

⁸⁸ VHA Directive 1164, *Essential Medication Information Standards*, June 26, 2015.

⁸⁹ TJC. National Patient Safety Goal standard NPSG.03.06.01.

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.⁹⁰

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 29 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.⁹¹ The OIG evaluated the following performance indicators:

- Justification for medication initiation
- Evidence of patient and/or caregiver education specific to the medication prescribed
- Clinician evaluation of patient and/or caregiver understanding of the education provided
- Medication reconciliation

Geriatric Care Conclusion

Generally, the OIG found compliance with providers justifying the reason for medication initiation and reconciling the patients' medications. However, the OIG identified that clinicians provided inadequate patient and/or caregiver education and evaluation of understanding related to newly prescribed medications that warranted a recommendation for improvement.

Specifically, TJC requires that clinicians educate patients and families about safe and effective use of medications and evaluate patient/caregiver understanding of the education provided.⁹² VHA also stipulates that the care "must be recorded and authenticated [in the medical record] immediately after the care event to ensure that the proper documentation is available. This ensures quality patient care."⁹³ The OIG estimated that clinicians provided education to 48 percent of the patients at the facility, based on the electronic health records reviewed.⁹⁴ In addition, the OIG estimated that clinicians assessed understanding of education provided to 57 percent of the patients.⁹⁵ Medication education is important for patients to be able to manage

⁹⁰ VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.

⁹¹ The seven selected antidepressant medications are amitriptyline, clomipramine, desipramine, doxepin (>6mg/day), imipramine, nortriptyline, and paroxetine.

⁹² TJC. Provision of Care standard PC.02.03.01, EP10.

⁹³ VHA Handbook 1907.01.

⁹⁴ The OIG is 95 percent confident that the true compliance rate is somewhere between 29.5 and 66.6 percent, which is statistically significantly below the 90 percent benchmark.

⁹⁵ The OIG is 95 percent confident that the true compliance rate is somewhere between 30.0 and 83.3 percent, which is statistically significantly below the 90 percent benchmark.

their health at home.⁹⁶ The Mental Health, Primary and Specialty Medicine, and Pharmacy service chiefs reported providers were educating patients and evaluating their understanding but failed to document these actions in the patients' electronic health records as they were unaware of the requirement.

Recommendation 3

3. The chief of staff ensures that clinicians provide and document patient/caregiver education and evaluate understanding of education provided about newly prescribed medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: May 30, 2020

Facility response: The chief of staff ensures clinicians assess and document the patient/caregiver's understanding of education regarding the safe and effective use of newly prescribed medications. On October 9th, 2019, the St. Cloud VA Pharmacy & Therapeutics Committee recommended implementation of the VISN 23 Clinical Reminder Order Check (CROC) for Anticholinergic/Antidepressant Use in the Elderly. The CROC alerts prescribers of the best practice for documentation of risk/benefit discussion and shared decision making when ordering the medication. It alerts the provider to schedule a follow up appointment within one month to assess for adverse effects and effectiveness of the antidepressant. The CROC alert also advises the provider that prior to continuing the medication there will be an assessment for adverse effects and effectiveness of the antidepressant, and adherence to the prescribed dosage.

Compliance monitoring will be conducted in the following manner:

All providers who initiate or continue an anticholinergic antidepressant medication on a Veteran who is age 65 or older will have documentation to support Veteran's understanding of specific education regarding the safe and effective use of the newly prescribed antidepressant.

Numerator = Number of Veterans (to exclude non-VA care) 65 and older with appropriate documentation of the assessment of the Veteran and caregiver's understanding of education about the safe and effective use of the newly prescribed or renewed antidepressant.

Denominator = Number of Veterans (to exclude non-VA care) 65 and older who are prescribed or renewed anticholinergic antidepressants. An audit of 5 charts per provider will be reviewed Quarterly with a target of 90% compliance. The audit will continue until a compliance rate of 90% is maintained for two consecutive Quarters. The results will be reported to Quality, Safety, and Value Executive Council and Pharmacy and Therapeutics Committee.

⁹⁶ TJC. Provision of Care standard PC.02.03.01

Women’s Health: Abnormal Cervical Pathology Results Notification and Follow-Up

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.⁹⁷ Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.⁹⁸ In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.⁹⁹ Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.¹⁰⁰

VA is authorized to provide “gender-specific services, such as Papanicolaou tests (Pap smears),” to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.¹⁰¹

VHA requires that each facility have a “full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women’s health care.” VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women’s health program. Each facility must also have a “Women Veterans Health Committee (WVHC) comprised of appropriate facility leadership and program directors, which develops and implements a Women’s Health Program strategic plan.” The Women Veterans Health Committee must meet at least quarterly and report to the executive leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.¹⁰²

VHA has established time frames for notifying patients of abnormal cervical pathology results. Abnormal cervical pathology results must be communicated to patients within seven calendar days from the date the results are available to the ordering provider. Communication of the

⁹⁷ Centers for Disease Control and Prevention. “Cervical Cancer” *Inside Knowledge* fact sheet, December 2016. https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf. (The website was accessed on February 28, 2018.)

⁹⁸ Centers for Disease Control and Prevention. *Basic Information About Cervical Cancer*, February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

⁹⁹ Centers for Disease Control and Prevention. *What Are the Risk Factors for Cervical Cancer?* February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/risk_factors.htm. (The website was accessed on March 8, 2019.)

¹⁰⁰ Centers for Disease Control and Prevention. *Basic Information About Cervical Cancer*, February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

¹⁰¹ VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended July 24, 2018).

¹⁰² VHA Directive 1330.01(2).

results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.¹⁰³

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The team also reviewed the electronic health records of 23 women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Appointment of a women veterans program manager
- Appointment of a women's health medical director or clinical champion
- Facility Women Veterans Health Committee
 - Core membership
 - Quarterly meetings
 - Reports to clinical executive leaders
- Collection and tracking of cervical cancer screening data
 - Notification of patients due for screening
 - Completed screenings
 - Results reporting
 - Follow-up care
- Communication of abnormal results to patients within required time frame
- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women's Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including requirements for a designated women veterans program manager and women's health medical director, clinical oversight of the women's health program, tracking of data related to cervical cancer screenings, communication of results to patients within the required time frame, and follow-up care when indicated. The OIG noted a concern with the Women Veterans Health Committee core membership that warranted a recommendation for improvement.

Specifically, VHA requires that the core membership of the Women Veterans Health Committee includes a women veterans program manager; a women's health medical director;

¹⁰³ VHA Directive 1330.01(2).

“representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care; and a member from executive leadership.”¹⁰⁴ The OIG reviewed the Women Veterans Health Committee minutes from March 2019 and June 2019 and found the committee lacked representation from pharmacy, mental health, radiology, and laboratory. This resulted in an absence of expertise and oversight in data review and analysis as the committee planned and carried out improvements for quality and equitable care for women veterans. The women veterans program manager was reportedly unaware until June 25, 2019, that pharmacy was not represented on the committee, and stated that a lack of oversight led to the lack of representation from the other clinical departments.

Recommendation 4

4. The facility director ensures that the Women Veterans Health Committee is comprised of the required core members and monitors committee’s compliance.

Facility concurred.

Target date for completion: January 31, 2020

Facility response: This Women Veterans Health Committee continues to meet quarterly. Committee membership has been reviewed and there are now representatives from all required departments listed in accordance with VHA Directive 1330.03 on the Women Veterans Health Committee. All required representatives (women veterans program manager, women health medical director, representatives from primary care, mental health, medical and or surgical subspecialties, gynecology, pharmacy, social work, nursing, radiology, laboratory, quality management, business office/non-VA medical care, and a member of the executive leadership team) have been advised of the need to send a representative if they are unable to attend the Women Veterans Health Committee meetings. Attendance will be documented in the Women Veterans Health Committee minutes, which are submitted to the Quality, Safety, and Value Executive Council and the Medical Staff Executive Council.

Numerator = Number of required members attending the meeting

Denominator = Number of required members

A compliance rate of 90% will be achieved for six consecutive months. The data will be presented at the Quality, Safety, and Value Executive Council (co-chaired by the facility director) monthly meeting on an ongoing basis to monitor for compliance and sustainment.

¹⁰⁴ VHA Directive 1330.01(2).

High-Risk Processes: Operations and Management of Emergency Departments and Urgent Care Centers

VHA defines an emergency department as a “unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations.” An urgent care center (UCC) “provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries.”¹⁰⁵ A variety of emergency services may exist, dependent on “capability, capacity, and function of the local VA medical facility;” however, emergency care must be uniformly available in all VHA emergency departments and UCCs.¹⁰⁶

Because the emergency department or UCC is often the first point of contact for patients seeking treatment of unexpected medical issues, a care delivery system with appropriate resources and services must be available to deliver prompt, safe, and appropriate care. VHA requires that each emergency department provide “unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week.” VHA UCCs are also required to provide access and timely care during established operational hours. VHA also requires that “evaluation, management, and treatment [are] provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care.”¹⁰⁷

TJC noted that patient flow problems pose a persistent risk to quality and safety and established standards for the management of the flow of patients in the emergency department and the rest of the hospital. Managing the flow of patients prevents overcrowding, which can “undermine the timeliness of care and, ultimately, patient safety.” Effective management processes that “support patient flow [in the emergency department or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care.”¹⁰⁸

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement initiative to improve the quality of emergent and urgent care provided through VA emergency departments and UCCs. As part of this initiative, all VA emergency departments and UCCs must use the Emergency Department Integration Software (EDIS) tracking program to document and manage the flow of patients.¹⁰⁹

¹⁰⁵ VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016 (amended March 7, 2017).

¹⁰⁶ VHA Directive 1101.05(2).

¹⁰⁷ VHA Directive 1101.05(2).

¹⁰⁸ TJC. Leadership standard LD.04.03.11.

¹⁰⁹ VHA Directive 1101.05(2); the Emergency Medicine Management Tool (EMMT) uses data collected from EDIS to generate productivity metrics. The use of EDIS and EMMT are key tools in accomplishing Emergency Medicine Improvement initiative goals.

VA emergency departments and UCCs must also be designed to promote a safe environment of care.¹¹⁰ Managers must ensure medications are securely stored,¹¹¹ a psychiatric intervention room is available,¹¹² and equipment and supplies are readily accessible to provide gynecologic and resuscitation services. VHA also requires emergency departments to have communication systems available to accept requests by local emergency medical services for transporting unstable patients to VA emergency departments.¹¹³

The OIG examined the clinical risks of the emergency department/UCC areas by evaluating the staffing; the provision of care, including selected aspects of mental health and women's health; and the reduction of patient safety risks to optimize quality care and outcomes in those areas. In addition to conducting manager and staff interviews, the OIG team reviewed emergency department staffing schedules, committee minutes, and other relevant documents. The OIG evaluated the following performance indicators:

- General
 - Presence of an emergency department or UCC
 - Availability of acute care medical and/or surgical inpatient beds in facilities with emergency departments
 - Emergency department/UCC operating hours
 - Workload capture process
- Staffing for emergency department/UCC
 - Dedicated medical director
 - At least one licensed physician privileged to staff the department at all times
 - Minimum of two registered nurses on duty during all hours of operation
 - Backup call schedules for providers
- Support services for emergency department/UCC
 - Access during regular hours, off hours, weekends, and holidays
 - On-call list for staff required to respond

¹¹⁰ VHA Directive 1101.05(2).

¹¹¹ TJC. Medication Management standard MM.03.01.01.

¹¹² A psychiatric intervention room is where individuals experiencing a behavioral health crisis, including serious disturbances, agitation, or intoxication may be taken immediately on arrival.

¹¹³ VHA Directive 1101.05(2).

- Licensed independent mental health provider available as required for the facility's complexity level
- Telephone message system during non-operational hours
- Inpatient provider available for patients requiring admission
- Patient flow
 - EDIS tracking program
 - Emergency department patient flow evaluation
 - Diversion policy
 - Designated bed flow coordinator
- General safety
 - Directional signage to after-hours emergency care
 - Fast tracks¹¹⁴
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable
- Women veteran services
 - Capability and equipment for gynecologic examinations
- Life support equipment

High-Risk Processes Conclusion

Generally, the facility achieved the performance indicators listed above. The OIG made no recommendations.

¹¹⁴ The emergency department fast track is a designated care area within the emergency department domain where lower acuity patients are assessed and treated.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	<ul style="list-style-type: none"> • Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation and/or for-cause surveys and oversight inspections • Factors related to possible lapses in care • VHA performance data 	Four OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director and chief of staff. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Medical Staff Privileging	<ul style="list-style-type: none"> • Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Service chiefs include specialty-specific criteria in OPPEs.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	<ul style="list-style-type: none"> • Parent facility <ul style="list-style-type: none"> ○ General safety ○ Environmental cleanliness and infection prevention ○ General privacy ○ Women veterans program ○ Availability of medical equipment and supplies • Community based outpatient clinic <ul style="list-style-type: none"> ○ General safety ○ Environmental cleanliness and infection prevention ○ General privacy ○ Women veterans program ○ Availability of medical equipment and supplies • Locked inpatient mental health unit <ul style="list-style-type: none"> ○ Mental health environment of care rounds ○ Nursing station security ○ Public area and general unit safety ○ Patient room safety ○ Infection prevention ○ Availability of medical equipment and supplies • Emergency management <ul style="list-style-type: none"> ○ Hazard vulnerability analysis (HVA) ○ Emergency operations plan (EOP) ○ Emergency power testing and availability 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	<ul style="list-style-type: none"> • Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	<ul style="list-style-type: none"> • Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Mental health and primary care providers complete MST mandatory training within the required time frame.
Geriatric Care: Antidepressant Use among the Elderly	<ul style="list-style-type: none"> • Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation 	<ul style="list-style-type: none"> • Clinicians provide and document patient/ caregiver education and evaluate understanding of education provided about newly prescribed medications. 	<ul style="list-style-type: none"> • None
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	<ul style="list-style-type: none"> • Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • The Women Veterans Health Committee is comprised of the required core members.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	<ul style="list-style-type: none"> • Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated 		
<p>High-Risk Processes: Operations and Management of Emergency Departments and UCCs</p>	<ul style="list-style-type: none"> • General • Staffing for emergency department/UCC • Support services for emergency department/UCC • Patient flow • General safety • Medication security and labeling • Management of patients with mental health disorders • Emergency department participation in local/ regional EMS system • Women veteran services • Life support equipment 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low complexity (3) affiliated¹¹⁵ facility reporting to VISN 23.¹¹⁶

**Table B.1. Facility Profile for St. Cloud VA Health Care System (656/00)
(October 1, 2015, through September 30, 2018)**

Profile Element	Facility Data FY 2016 ¹¹⁷	Facility Data FY 2017 ¹¹⁸	Facility Data FY 2018 ¹¹⁹
Total medical care budget in dollars	\$260,444,586	\$288,600,711	\$313,771,385
Number of:			
• Unique patients	38,749	39,016	39,143
• Outpatient visits	432,190	427,761	439,877
• Unique employees ¹²⁰	1,468	1,428	1,484
Type and number of operating beds:			
• Community living center	225	225	225
• Domiciliary	148	148	148
• Mental health	15	15	15
Average daily census:			
• Community living center	204	185	203
• Domiciliary	136	135	136
• Mental health	8	9	11

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse

Note: The OIG did not assess VA's data for accuracy or completeness.

¹¹⁵ Associated with a medical residency program.

¹¹⁶ The VHA medical centers are classified according to a facility complexity model; a designation of “3” indicates a facility with “low volume, low-risk patients, few or no complex clinical programs, and small or no research and teaching programs.”

¹¹⁷ October 1, 2015, through September 30, 2016.

¹¹⁸ October 1, 2016, through September 30, 2017.

¹¹⁹ October 1, 2017, through September 30, 2018.

¹²⁰ Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles¹²¹

The VA outpatient clinics in communities within the catchment area of the facility provide primary care integrated with women’s health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table B.2. provides information relative to each of the clinics.

Table B.2.VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2017, through September 30, 2018)¹²²

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ¹²³ Provided	Diagnostic Services ¹²⁴ Provided	Ancillary Services ¹²⁵ Provided
Montevideo, MN	656GB	4,784	1,248	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Nephrology Neurology Rheumatology Anesthesia	EKG	Pharmacy Weight management Nutrition

¹²¹ Includes all outpatient clinics in the community that were in operation as of February 8, 2019.

¹²² The definition of an “encounter” can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015, and has not been updated.) An encounter is a “professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.”

¹²³ Specialty care services refer to non-primary care and non-mental health services provided by a physician.

¹²⁴ Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

¹²⁵ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

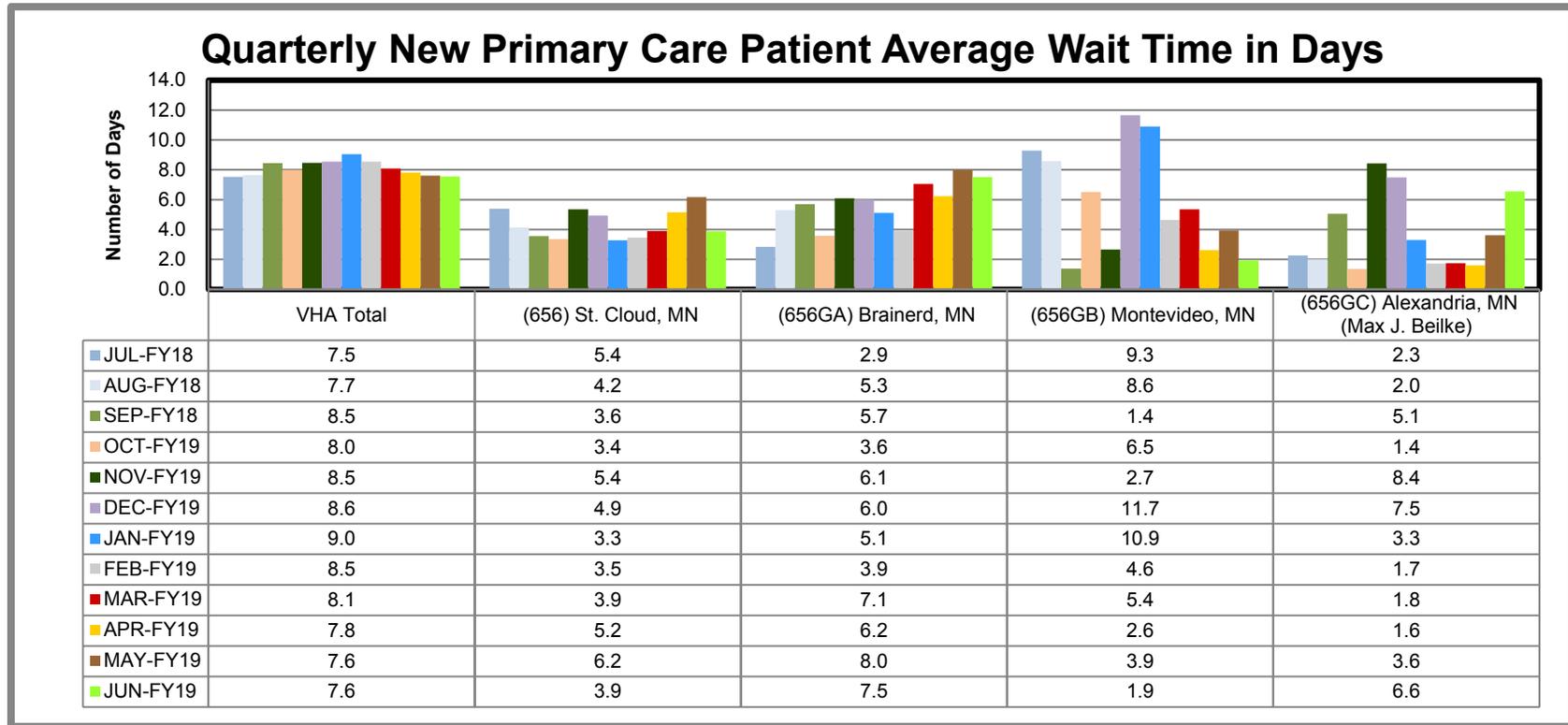
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ¹²³ Provided	Diagnostic Services ¹²⁴ Provided	Ancillary Services ¹²⁵ Provided
				Urology Vascular		
Alexandria, MN	656GC	6,297	2,455	Cardiology Dermatology Endocrinology Gastroenterology Infectious disease Nephrology Neurology Pulmonary/ Respiratory disease Rheumatology Anesthesia General surgery GYN Otolaryngology Urology Vascular	EKG	Pharmacy Weight management' Nutrition
Brainerd, MN	656GA	13,559	3,727	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious disease Nephrology Neurology	EKG	Pharmacy Social work Weight management Nutrition

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ¹²³ Provided	Diagnostic Services ¹²⁴ Provided	Ancillary Services ¹²⁵ Provided
				Pulmonary/ Respiratory disease Rheumatology Poly-trauma Anesthesia Eye General surgery Orthopedics Otolaryngology Podiatry Urology Vascular		

Source: VHA Support Service Center and VA Corporate Data Warehouse

Note: The OIG did not assess VA's data for accuracy or completeness.

Appendix C: Patient Aligned Care Team Compass Metrics¹²⁶



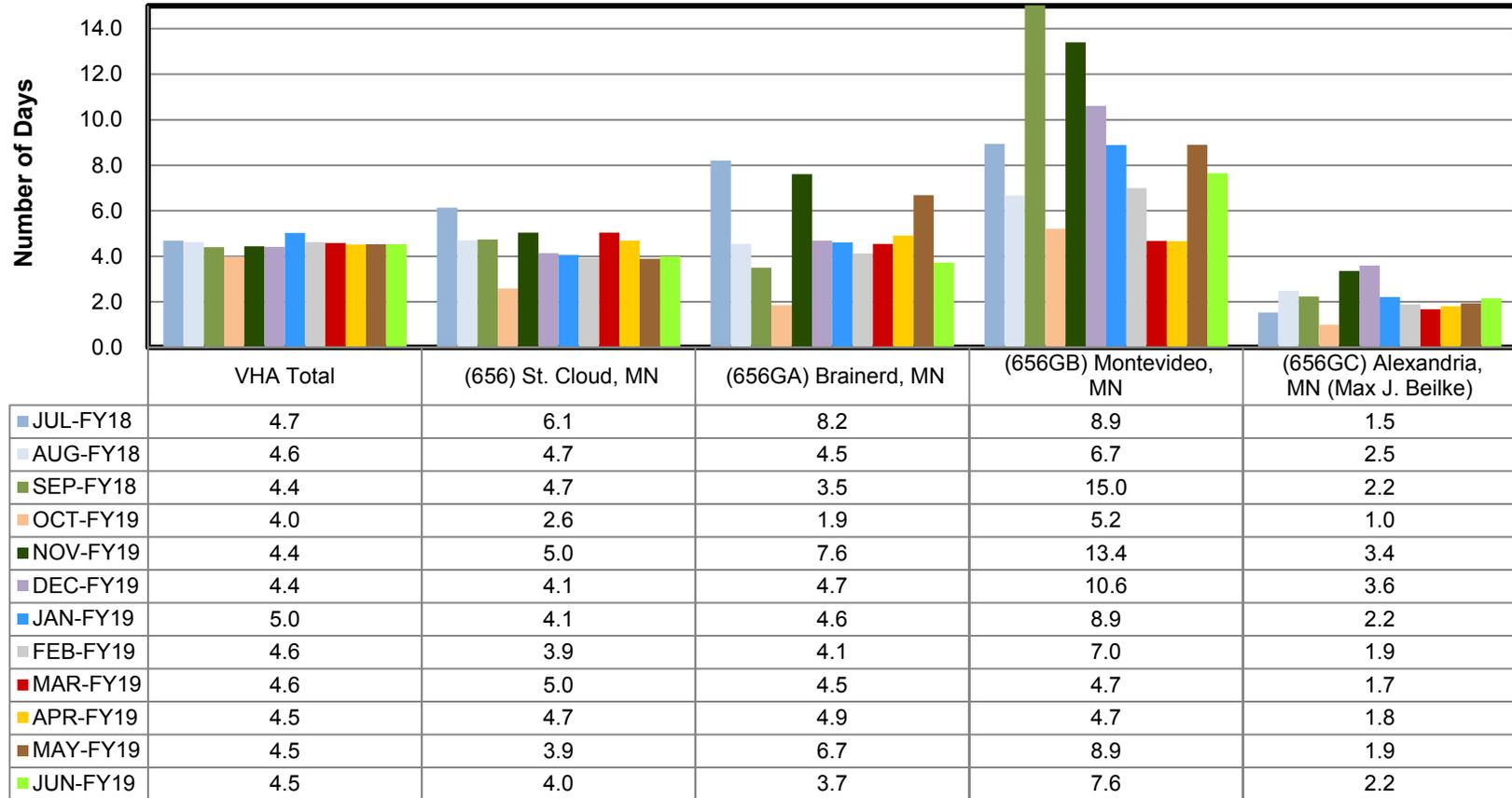
Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness.

Data Definition: “The average number of calendar days between a New Patient’s Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.” Note that prior to FY15, this metric was calculated using the earliest possible create date.

¹²⁶ Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 13, 2018.

Quarterly Established Primary Care Patient Average Wait Time in Days



Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness.

Data Definition: “The average number of calendar days between an Established Patient’s Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.”

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions¹²⁷

Measure	Definition	Desired Direction
ACSC hospitalization	Ambulatory care sensitive conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit reviews met	Percent acute admission reviews that meet interqual criteria	A higher value is better than a lower value
APP capacity	Advanced practice provider capacity	A lower value is better than a higher value
Best place to work	All employee survey best places to work score	A higher value is better than a lower value
Call responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Care transition	Care transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont stay reviews met	Percent acute continued stay reviews that meet interqual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/capacity	Efficiency and physician capacity	A higher value is better than a lower value
Employee satisfaction	Overall satisfaction with job	A higher value is better than a lower value

¹²⁷ VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated December 26, 2018). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public.)

Measure	Definition	Desired Direction
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS like – HED90_1	HEDIS-EPRP based PRV TOB BHS	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS-eOM based DM IHD	A higher value is better than a lower value
MH wait time	Mental health care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	ORYX	A higher value is better than a lower value
PC routine care appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC urgent care appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
Physician capacity	Physician capacity	A lower value is better than a higher value
PC wait time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value

Measure	Definition	Desired Direction
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value

Measure	Definition	Desired Direction
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC routine care appt	Timeliness in getting a SC routine care appointment (specialty care)	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SC urgent care appt	Timeliness in getting a SC urgent care appointment (specialty care)	A higher value is better than a lower value
Seconds pick up calls	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty care wait time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value
Telephone abandonment rate	Telephone abandonment rate	A lower value is better than a higher value

Source: VHA Support Service Center

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions¹²⁸

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
Falls with major injury (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
High risk PU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
Improvement in function (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Moderate-severe pain (SS)	Short-stay measure: percent of residents who self-report moderate to severe pain.
New or worse PU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
Newly received antipsych meds (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

¹²⁸ *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>. (The website was accessed on September 3, 2019, but is not accessible by the public.)

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 13, 2019

From: Director, VA Midwest Health Care Network (10N23)

Subj: Comprehensive Healthcare Inspection of the St. Cloud VA Health Care System, MN

To: Director, Chicago Office of Healthcare Inspections (54CH02)

Director, GAO/OIG Accountability Liaison (VHA 10EG GOAL Action)

I have reviewed and concur with the findings and recommendations in the report of the Comprehensive Healthcare Inspection Review.

Corrective action plans have been established with planned completion dates, as detailed in the report.

(In the absence of:)

Jason Petti

Deputy Network Director

Robert P. McDivitt, FACHE

Network Director

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix G: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 8, 2019

From: Director, St. Cloud VA Health Care System (656/00)

Subj: Comprehensive Healthcare Inspection of the St. Cloud VA Health Care System, MN

To: Director, VA Midwest Health Care Network (10N23)

1. Thank you for conducting the Comprehensive Healthcare Inspection Review at the St. Cloud VA Health Care System the week of July 15, 2019.
2. We appreciate The Office of Inspector General assisting us with improving the quality of healthcare for our nation's Veterans.
3. I have reviewed and concur with the findings and recommendations in the report of the Comprehensive Healthcare Inspection Review.
4. Corrective action plans have been established with planned completion dates, as detailed in the report.

(Original signed by:)

Brent A. Thelen, PhD

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

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